SUBCOMMITTEE #3:
Health & Human Services

Chair, Senator Mark DeSaulnier

Senator Elaine K. Alquist
Senator Bill Emmerson

May 21, 2012

10:00 AM
Room 3191

(Michelle Baass)

PLEASE NOTE:

Only those items contained in this agenda will be discussed at this hearing. *Please* see the Senate Daily File for dates and times of subsequent hearings.

Issues will be discussed in the order as noted in the Agenda unless otherwise directed by the Chair.

Pursuant to the Americans with Disabilities Act, individuals who, because of a disability, need special assistance to attend or participate in a Senate Committee hearing, or in connection with other Senate services, may request assistance at the Senate Rules Committee, 1020 N Street, Suite 255 or by calling 916-324-9335. Requests should be made one week in advance whenever possible. Thank you.

VOTE ONLY CALENDAR

A. 4260 Department of Health Care Services

1. Medi-Cal Estimate Update—Technical Adjustments (DOF Issue 120)

May 2012 Medi-Cal Estimate. It is requested that the adjustments noted below be made to the following budget bill items to reflect a variety of caseload and cost changes not highlighted in the other Medi-Cal proposals:

1. Item 4260-101-0001 be decreased by $707,126,000 and reimbursements be decreased by $475,205,000
2. Item 4260-101-0080 be decreased by $57,000
3. Item 4260-101-0890 be increased by $1,229,902,000
4. Item 4260-101-3168 be increased by $8,009,000
5. Item 4260-105-0001 be increased by $3,216,000
6. Item 4260-106-0890 be decreased by $13,798,000
7. Item 4260-111-0001 be decreased by $302,000 (Every Woman Counts)
8. Item 4260-113-0001 be decreased by $2,778,000
9. Item 4260-117-0001 be increased by $3,315,000
10. Item 4260-107-0890 be decreased by $61,000
11. Item 4260-113-0890 be decreased by $10,105,000
12. Item 4260-117-0890 be increased by $22,334,000

Subcommittee Staff Comment & Recommendation—Approve. It is recommended to approve the above adjustments, with any changes to conform as appropriate to other actions that have been or will be taken. This is a technical adjustment.

2. Medi-Cal Provider Payment Reductions (DOF Issue 126)

Budget Issue. The May Revision proposes to increase General Fund expenditures by $174 million to reflect a change in the implementation date from March 1, 2012 to October 1, 2012, due to current court injunctions barring implementation of rate reductions.

Background. AB 97 (Statutes of 2011) requires the Department to implement a 10% provider payment reduction, which will affect all services except hospital inpatient and outpatient services, critical access hospitals, federal rural referral centers and FQHCs/RHCs, services provided through the Breast and Cervical Cancer Treatment and Family Planning, Access, Care and Treatment (Family PACT) programs, and hospice services. Payments to facilities owned or operated by the State Department of Mental Health or the State Department of Developmental Services and payments funded by certified public expenditure and intergovernmental transfer are exempt.

On December 28, 2011, the U.S. District Court, Central District of California, issued preliminary injunctions in the cases of *California Hospital Association, et al. v. Douglas et al.* and *Managed Pharmacy Care, et al. v. Sebelius, et al.* against the implementation of AB 97 payment reductions for distinct part nursing facilities and pharmacy services. In compliance with these injunctions, the Department is prohibited from implementing these reductions.

On January 10, 2012, the same court issued a preliminary injunction in the case of *California Medical Transportation Association v. Douglas, et al.* prohibiting the Department from implementing AB 97 payment reductions for nonemergency medical transportation providers.

On January 31, 2012, a preliminary injunction was issued in the case of *California Medical Association, et al. v. Douglas, et al.* against the implementation of AB 97 payment reductions for physicians, clinics, dentists, pharmacists, ambulance providers, and providers of medical supplies and durable medical equipment. In compliance with this injunction, the Department is prohibited from implementing these reductions.

Appeals in all four cases have been filed.

On February 22, 2012, the United States Supreme Court issued its decision in the *Douglas v. Independent Living Center* Medi-Cal payment reductions cases. The 5/4 majority opinion vacated all of the Ninth Circuit decisions that were before it and remanded the cases to the Ninth Circuit Court of Appeals to reassess the plaintiffs' preemption/Supremacy Clause claims in light of the Centers for Medicare & Medicaid Services (CMS) approval of the State Plan Amendments (SPA) at issue in a number of those cases. The Supreme Court also strongly indicated that, on remand, the Ninth Circuit should show deference to CMS decisions to approve the SPAs, noting that CMS approval "carries weight".

Subcommittee Staff Comment and Recommendation—Approve. It is recommended to approve this item to reflect DHCS's estimate on the implementation date of these reductions.

3. Family Health Estimate – CHDP, CCS, GHPP (DOF Issue 199)

Budget Issue. The May Revision proposes an overall net increase of $5.8 million (General Fund) in the Family Health Programs which includes the Genetically Handicapped Persons Program (GHPP), the California Children's Services (CCS) Program, and the Child Health and Disability Prevention (CHDP) Program.

The May Revision proposes technical fiscal adjustments and caseload adjustments to three distinct programs within Family Health. These are as follows:

- *Genetically Handicapped Persons Program (GHPP).* Total expenditures of $99.7 million ($68.2 million General Fund, $23.1 million federal Safety Net Care Pool, $8 million Rebate Fund, and $452,000 Enrollment Fees) are proposed for 2012-13. This includes a $2.4 million General Fund increase from the January budget due to the costs of Kalydeco for the treatment of patients, six years of age and older, with cystic fibrosis and a reduction of $2.5 million in Safety Net Care Pool funds. Total caseload is 858 people.
- *California Children's Services Program (CCS).* Total expenditures of $230.4 million ($68.9 million General Fund and $161.5 million federal funds) are proposed for 2012-13. Total caseload is estimated to be 29,624 children.
- *Child Health & Disability Prevention (CHDP) Program.* Total expenditures of $2.76 million ($2.7 million General Fund, and $22,000 Children's Lead Poisoning Prevention Funds) are proposed for 2012-13. Total caseload is estimated to be 42,228 children.

In addition, the May Revision proposes a reduction of $41.1 million ($10.2 million General Fund) by shifting children in the Healthy Families Program carve-out portion of the CCS Program to Medi-Cal to coincide with the Administration's proposal on merging the Healthy Families Program into the Medi-Cal Program based on a phase-in transition beginning October 1, 2012. *It should be noted that any Subcommittee #3 action taken with regards to the merger of the Healthy Families Program into the Medi-Cal Program will conform to the CCS Program where applicable to ensure continuity of services for children enrolled in the CCS Program.*

Subcommittee Staff Comment and Recommendation—Adopt May Revision. No issues have been raised regarding this estimate package for these three programs. *This action will be adjusted to conform where necessary to any action taken with regards to the transition of Healthy Families Program enrollees into the Medi-Cal Program.*

Please note that the Administration's proposal to add a financial eligibility test for the CCS Medical Therapy Program will be discussed at the May 24, 2012 Subcommittee #3 hearing.

4. CMAC Staff Transition

Budget Issue. The budget proposes trailer bill language to create a transition plan for the staff of the California Medical Assistance Commission (CMAC) and redirects the twelve non-commissioner positions, in their exempt status, to DHCS on July 1, 2012. These positions would be funded with $658,000 General Fund and $657,000 federal funds.

The CMAC staff will continue to operate the Selective Provider Contracting Program (SPCP) until the new inpatient hospital payment system based on diagnosis-related groups (DRG) is implemented. Upon implementation of the DRG payment system, the twelve exempt positions will be abolished, at which point the CMAC staff shall be transferred into civil service classifications, for which they are eligible, within DHCS.

Background. CMAC is responsible for negotiating contracts under the SPCP for Medi-Cal fee-for-service (FFS) hospital inpatient services statewide. AB 102 (Statutes of 2011) dissolved CMAC and transferred its resources and functions to DHCS effective July 1, 2012. Additionally, DHCS was required to develop and implement a new payment system based on diagnosis-related groups and submit a CMAC resource transition plan to be included in the 2012-13 Budget.

Subcommittee Comment and Recommendation—Approve. This proposal is consistent with state law. No issues have been raised regarding this proposal. It is recommended for approval.

5. Privacy and Security of Medi-Cal Information

Budget Issue. The DHCS requests the extension of ten limited-term positions that are scheduled to expire on June 30, 2012. These staff would continue to perform the ongoing workload of managing, protecting, and securing confidential Medi-Cal eligibility information, ensuring compliance with the requirements of the federal Social Security Administration (SSA), and monitoring access to the Medi-Cal Eligibility Data System (MEDS). The total cost of these resources is $1.4 million ($585,000 General Fund).

These positions would perform the following workload (beyond June 30, 2012):

- Maintenance of Data Sharing Agreements with SSA. DHCS entered into an ongoing agreement with SSA on July 1, 2010. New security requirements are added annually as part of this contract and DHCS staff needs to ensure continued compliance. DHCS must continually assess data sharing requirements to analyze reports containing SSA data as well as MEDS access to ensure compliance with SSA requirements.

- Contract with County Welfare Departments. DHCS has entered into agreements with each of the 58 county welfare departments regarding the confidentiality of MEDS data. DHCS requires continued staff resources to monitor and ensure compliance.

- Assess and Monitor County Security Compliance. DHCS must perform onsite security reviews of all 58 counties and their County Welfare Department offices, approve corrective action plans, and advise and work with counties on remediation efforts.

- Facilitate Access for Other State Agencies and Business Partners. DHCS serves as the lead California agency to transmit federal SSA data and other public assistance program eligibility data contained in MEDS to other state agencies. DHCS needs continued staff resources to provide system access and negotiate and monitor access levels.

Background. DHCS is the single state agency responsible for the administration of the Medi-Cal program, and as such, must monitor and protect the privacy and security of Medi-Cal information. Additionally, DHCS has entered into a data sharing agreement with SSA and must comply with data sharing requirements.

Subcommittee Staff Comment and Recommendation–Approve. No issues have been raised regarding this proposal. The workload for these positions is justified.

6. Positions for HIPAA

Budget Issue. The DHCS is requesting to change 14 limited-term positions to permanent to address new Health Insurance Portability and Accountability Act of 1996 (HIPAA) rules and maintain adherence to state and federal privacy requirements. The requested positions would cost $1.9 million ($723,000 General Fund).

Though HIPAA was enacted at the federal level in 1996, both the health care industry and the federal CMS have recognized that HIPAA requirements are far more difficult to implement than originally estimated and have ongoing impacts for all subsequent system changes, requiring longer time periods to fully comply. Several HIPAA rules are still pending release and several have been updated by the federal CMS and required system changes.

Background. HIPAA, enacted in 1996, outlines a process to achieve national uniform health data standards and health information privacy in the U.S. It requires the adoption of standards by the federal Secretary of Health and Human Services to support the electronic exchange of a variety of administrative and financial health care transactions. The federal government has published and continues to publish, multiple rules pertaining to the implementation of HIPAA. These rules will be published in waves and over the next several years. Among the standards are:

- Electronic transaction and data elements for health claims and equivalent encounter information, claims attachments, health care payment and remittance advice, health plan enrollment and disenrollment, health plan eligibility, health plan premium payments, first report of injury, health claim status and other items;
- Unique identifiers for individuals, employers, health plans and health care providers for use in the health care system;
- Code sets and classification systems for the data elements of the transactions identified (conversion of all local codes to national standard codes); and
- Security and Privacy standards for health information.

New HIPPA regulations released in January 2009, often referred to as “HIPAA-2” because of the major change in standards, identified significant revisions to the transactions and code set standards under HIPAA including:

- All HIPAA-covered transactions must begin using the International Classification of Diseases, 10th Edition, (ICD-10) by October 2013 for patient diagnoses and inpatient medical procedures. The more than 800 percent increase in codes included in the new standard will impact the way virtually every clinician and facility bills for health care services. For payers, such as Medi-Cal, it will impact numerous program policies, claim payment edits, the ability to analyze data, and make program decisions going forward.

Additionally, the Affordable Care Act includes significant HIPAA-related changes regarding HIPAA update frequency, operating rules, transaction standards, health plan certification requirements, and penalties for noncompliance.

Subcommittee Staff Comment and Recommendation–Approve. While it was originally established as a temporary program, HIPAA activities have grown into an ongoing workload for DHCS. Workload for these positions is justified. It is recommended for approval.

7. Every Women Counts Technical Adjustment (DOF Issue 109)

Budget Issue. In the May Revision, the DHCS requests a technical adjustment to shift $1.3 million ($1.2 million Breast Cancer Control Account and $50,000 federal funds) State Operations funding to Local Assistance for the Every Women Counts (EWC) Program. This conforms to DHCS budgeting structure and provides accountability of Fiscal Intermediary costs.

The Governor's January budget proposed the transfer of EWC from the Department of Public Health to DHCS. This Subcommittee adopted this proposal on May 10, 2012.

Subcommittee Staff Comment and Recommendation—Approve. No issues have been raised regarding this proposal. It is recommended for approval.

8. Eliminate the Advisory Committee on Genetically Handicapped Persons

Budget Issue. In the May Revision, the DHCS proposes to eliminate the Advisory Committee on Genetically Handicapped Persons. This advisory committee was established in 1974 when the Genetically Handicapped Persons Program (GHPP) was created.

No person has ever been appointed to this committee and it has never been convened.

Subcommittee Staff Comment and Recommendation—Approve. It is recommended to approve the elimination of this advisory committee and to modify the Administration's proposed trailer bill language to give the DHCS Director the authority to expand the list of conditions covered by the program without the guidance of the advisory committee.

9. Radiology Rate Reduction

Budget Issue. SB 853 (Statutes of 2010) mandates that rates for radiology services may not exceed 80 percent of Medicare rates, effective October 1, 2010. In the Governor's January budget, DHCS estimated that it would begin implementation of the law in February 2012.

However, in the May Revision, DHCS now estimates that it would not begin implementation of this law until September 2012 because of inadequate staffing and other workload priorities.

Subcommittee Staff Comment and Recommendation. It is recommended to score an additional $6.6 million ($3.3 million General Fund) in savings by directing DHCS to begin implementation of this law in July 2012.

10. FQHC/RHC Audit Staffing

Budget Issue. The May Revision assumes no savings as a result of the reconciliation audits of Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) by DHCS audit staff. DHCS notes that these three limited-term auditor positions expire on June 30, 2012; and consequently, the estimate does not reflect any savings as a result of these audits.

Background. The department received three limited-term positions to perform audit activities for FQHC/RHC providers to account for the increasing number of providers and to fulfill statutory audit deadlines.

Subcommittee Staff Comment and Recommendation. Since this Subcommittee rejected the Administration's proposal to reform how FQHCs and RHCs are paid, it would still be important to ensure that audits are conducted to evaluate if these providers were paid an amount equal to their prospective payment system rate. It is recommended to redirect existing staff at DHCS to perform this workload and recognize $6.1 million ($3.1 million General Fund) in savings in 2012-13 as a result of the audit findings.

11. Medi-Cal Electronic Health Records – State Match

Background. The federal ARRA Stimulus Program, authorized in 2009, included funding for investments in health information technology (HIT) designed to modernize the delivery of health care services. Known as the HITECH Act, core elements of this program include incentive payments administered through Medicare (by the federal CMS) and Medi-Cal to encourage physicians, hospitals and other providers to adopt EHRs. The Medi-Cal EHR incentive payments are 100 percent federally funded. In addition, CMS provides 90 percent of the funds to operate the program. Over 9,200 California providers have registered to receive these incentive payments totaling more than $168 million. Additionally, 219 hospitals have also registered, and of these, 106 have already received federal incentive payments totaling $153 million and 34 others have been approved for payments totaling $65 million.

While the incentive payments are 100 percent funded by the federal government, the operating costs of the Medi-Cal EHR Incentive Payment Program require a 10 percent match by the state in order to draw down an additional 90 percent funding from the federal CMS. For the past year, the matching funds needed to startup the Medi-Cal EHR Incentive Payment

program have been provided by the California HealthCare Foundation (CHCF) in anticipation that the State would determine a sustainable solution to obtaining the minimal funds needed to operate the program. CHCF has notified the state that effective July 1, 2012, it will no longer be able to provide funds to operate the program. Therefore, unless a minimum of $188,529 is allocated by the state in 2012-13 to continue to operate the program, the State is in jeopardy of forfeiting hundreds of millions of dollars in federal funds.

Subcommittee Staff Comment and Recommendation. It is recommended to redirect $190,000 General Fund budgeted for Other Administration (postage and printing costs) to be used as the state match to operate the Medi-Cal EHR Incentive Payment Program. California providers are able to receive millions of dollars in federal funds as a result of this program.

12. Eliminate Sunset for LEA Medi-Cal Billing Option Program

Budget Issue. The DHCS proposes to (1) delete the current program sunset date of January 1, 2013, for the Local Educational Agency (LEA) Medi-Cal Billing Option (LBO) program, (2) eliminate requirements that a baseline LBO funding amount must be met prior to funding LBO contractor costs, and (3) remove the maximum annual funding amount of $1.5 million for contractor costs and makes the annual funding an amount agreed upon between DHCS and the LEA Ad Hoc Workgroup Advisory Committee.

Subcommittee Staff Recommendation—Reject. On March 22, 2012, this Subcommittee approved a modified version of this proposal. It is now recommended to reject this proposal (to conform to the action taken in Assembly Budget Subcommittee #1).

B. 4265 Department of Public Health

1. Licensing and Certification Program Estimate Update (DOF Issue 650)

Budget Issue. The May Revision reflects a decrease of $1.2 million ($1.3 million General Fund and $112,000 reimbursement fund increase) for the Licensing and Certification Program.

The reduction in General Fund is a result of technical workload adjustments for state-owned facilities.

Subcommittee Staff Comment and Recommendation—Approve. This is a technical adjustment, no issues have been raised.

2. Proposition 99 – Research Account Adjustment (DOF Issue 502)

Budget Issue. In the May Revision, DPH proposes a $1.049 million reduction in Proposition 99 Research Account funding ($936,000 for support of the California Cancer Registry and $113,000 for community outreach efforts for the California Cancer Registry). This proposal aligns Proposition 99 revenues with expenditures.

Subcommittee Staff Comment and Recommendation—Approve. It is recommended to adjust expenditures to reflect Proposition 99 revenues.

3. Expand California's Newborn Screening Program

Budget Issue. The DPH requests 10 permanent positions and the associated $5.3 million in state operations expenditure authority (from the Genetic Disease Testing Fund) to implement Assembly Bill 395, Chapter 461, Statues of 2011, which requires DPH to add Severe Combined Immunodeficiency (SCID) to the panel of disorders screened for by the Genetic Disease Screening Program Newborn Screening Program. The screening for SCID began on January 1, 2012.

This item was heard at the Subcommittee #3 Hearing on March 8, 2012.

Subcommittee Staff Comment and Recommendation—Approve. No issues have been raised regarding this proposal. It is consistent with state law and is recommended for approval.

4. Women, Infant, and Children (WIC) Program (DOF Issue 553)

Budget Issue. The May Revision includes an increase of $26 million from the WIC Manufacturer Rebate Fund in 2012-13, and a corresponding decrease in federal expenditure authority. The increase in rebate funds is a result of a new contract award for infant formula rebates effective August 1, 2012. Federal law requires the use of WIC manufacturer rebate revenues prior to using federal WIC food funds.

Subcommittee Staff Comment and Recommendation—Approve. No issues have been raised regarding this adjustment. It is recommended for approval.

C. 4280 Managed Risk Medical Insurance Board

1. County Health Initiative Matching Fund Caseload Update (DOF Issue 301)

Budget Issue. The May Revision reflects an increase to the County Health Initiative Matching Fund ($15,000) and federal funds ($29,000) as a result of a slight increase in program enrollment.

Subcommittee Staff Comment and Recommendation—Approve. No issues have been raised regarding this proposal.

2. AIM Caseload and Funding Update (DOF Issues 201 and 202)

Budget Issue. The May Revision includes adjustments to the Access for Infants and Mothers (AIM) budget to reflect a shift of program funding from state funds to federal funds and a reduction in Proposition 99 revenue transfers due to a decrease in program costs.

The MRMIB is no longer pursuing the option of using fee-for-service for AIM because federal funds cannot be claimed for post-partum care. In contrast, the current managed care bundled rate includes post-partum care (as well as labor and delivery) and MRMIB can claim federal funds for the entire bundled rate.

Subcommittee Staff Comment and Recommendation—Approve. No issues have been raised regarding this proposal.

3. Major Risk Medical Insurance Program (DOF Issue 402)

Budget Issue. As a condition for obtaining federal funding for the Pre-Existing Condition Insurance Plan (PCIP), the state must meet the maintenance of effort requirements to maintain Managed Risk Medical Insurance Program annual funding of $31.8 million (effective 2011-12). Consequently, the May Revision requests an increase in Proposition 99 funds ($226,000) to ensure that’s level of state funding meets these requirements.

Subcommittee Staff Comment and Recommendation—Approve. No issues have been raised regarding this proposal.

ISSUES FOR DISCUSSION

A. 4265 Department of Public Health

1. AIDS Drug Assistance Program (ADAP) Estimate Update (DOF Issues 561 and 651)

Budget Issue. The May Revision updates expenditures for the ADAP program. See table below.

Table: Comparison of January and May Estimates for ADAP for Budget Year (dollars in thousands)

Fund Source	January Budget	May Revise	Difference
General Fund	$4,446	$4,843	$397
AIDS Drug Rebate Fund	245,520	300,756	55,236
Federal Funds – Ryan White	102,572	113,605	11,033
Reimbursements-Medicaid Waiver	49,300	17,150	-32,150
Proposed New Premiums	2,000	1,361	-639
Total	**$403,838**	**$437,715**	**$33,877**

This updated estimate reflects the following:

- An increase in federal Ryan White funding of $11 million. This includes $2.6 million awarded on April 9, 2012 for ADAP Earmark and Ryan White Part B ADAP Supplemental federal funds and $8.4 million for the 2012 Ryan White Part B ADAP Supplemental Grant.
- The impact of full implementation of the “non-legacy” Low Income Health Program (LIHP) County Programs on ADAP. It is estimated that 1,991 ADAP clients will shift to LIHP in the non-legacy counties for an ADAP savings of $20.9 million. This was not accounted for in the January estimate.
- The impact of implementation of the legacy LHIP County Programs on ADAP. It is estimated that 8,076 ADAP clients will shift to LIHP in the legacy counties for an ADAP savings of $66.7 million. This updated estimate reflects the delay of implementation of the LIHP in Los Angeles and Alameda counties (estimated to begin July 1, 2012). The January estimate projected a larger shift of ADAP clients to LIHP in the current year and did not reflect the delayed implementation.
- An increase in the rebate percentage from an estimated 48 percent in January to 50 percent in the May Revision. Generally, for every dollar of ADAP drug expenditure, the program estimates it will obtain 50 cents in rebates. This 50 percent level is based on an average of rebate collections (both “mandatory” and “supplemental” rebates).
- A change to the Administration’s share-of-cost (SOC) budget proposal, to eliminate the SOC for ADAP clients with private insurance due to antiretroviral manufacturer’s co-pay assistance programs, delaying the implementation date to October 1, 2012.

Subcommittee Staff Comment and Recommendation. It is recommended to approve the updated May Revision estimate of ADAP with the exception of the share-of-cost proposal. This share-of-cost proposal was rejected by Subcommittee #3 on March 8, 2012.

Given the uncertainty of when ADAP clients may transition to LIHP, it is recommended to adopt placeholder uncodified trailer bill language to require the Department of Public Health to report to the Joint Legislative Budget Committee by October 1, 2012 on if any of the projections or assumptions used to develop ADAP's estimated budget for the Budget Act of 2012-13 may result in a potential funding shortfall or an inability of ADAP to provide services to eligible ADAP clients. If a potential funding shortfall occurs before October 1, 2012 and ADAP is unable to provide services to eligible ADAP clients, the Department of Public Health shall provide notification to the Joint Legislative Budget Committee within 15 calendar days of this determination.

Questions. The Subcommittee has requested DPH to respond to the following question:

1. Please provide an overview of the May Revision estimate for ADAP and discuss the key changes.

2. Transition of Ryan White/ADAP Clients to LIHP

Background. At the March 8, 2012 Subcommittee #3 hearing, concerns were discussed regarding OA's oversight and engagement in the transition of ADAP clients to LIHP. As a result of these concerns the Subcommittee #3 adopted placeholder trailer bill that would strengthen consumer protections for ADAP clients as they transition to LIHP and create a stakeholder advisory committee to give expert advice on transition policy decisions.

Since the March hearing, DPH, in conjunction with the Department of Health Care Services (DHCS), has:

- Conducted weekly calls with stakeholders (e.g., DHCS, HIV advocates, California Conference of Local AIDS Directors, California Association of Public Hospitals, County Health Executives Association of California, and county LIHP administrators).
- Created a Ryan White/LIHP stakeholder advisory committee which includes providers, case managers, HIV advocates, California Conference of Local AIDS Directors, California Association of Public Hospitals, County Health Executives Association of California, LIHP administrators, and HIV-positive consumers. This group will provide input on transition policy decisions and guidance.
- Issued guidance memos, summaries of topics discussed during monthly stakeholder calls, FAQs and resources which are posted to OA's website. See LIHP information.
- Conducted training sessions for ADAP enrollment workers and will host a series of trainings for Ryan White case managers and benefit counselors (beginning in May and to be completed before June 2012).
- Reached out to counties and HIV advocates to develop county specific consumer information sheets. These sheets will provide comprehensive guidance to clients including all of the client-relevant information about processes and procedures for a successful transition to LIHP.
- Created, based on feedback from HIV advocates, an ADAP to LIHP transition flowchart that visually displays the process and will serve as a good reference for ADAP enrollment workers, Ryan White case managers, Ryan White benefit counselors, and others for explaining the LIHP application process to clients. This chart can be found at: http://www.cdph.ca.gov/programs/aids/Documents/ADAPMMLIHPFlowchart.pdf

Additionally, it has worked with DHCS and counties on establishing grace periods to allow ADAP clients to submit proof that they have submitted a LIHP application to the county and to provide proof of the LIHP application determination. During these grace periods, ADAP pays for client medications. This grace period policy includes:

- If the client does not provide proof of a LIHP application within a 30-day grace period, then the client's ADAP eligibility is suspended but the next time they visit an ADAP pharmacy, the client receives one "last 30-day prescription fill".

- If the client provides proof of a LIHP application, then the client receives a county-specific LIHP application processing grace period (duration is determined by each county) ADAP pays for medications during this LIHP grace period. For example, Contra Costa County has a 45-day grace period and Orange County has a 90-day grace period. ADAP covers the cost of medications during these county-specific grace periods.

- If the client visits an ADAP pharmacy after the county-specific application processing grace period has expired, then again the client will received one "last 30-day prescription fill."

Subcommittee Staff Comment and Recommendation. Since March, DPH has taken steps to ensure continuity of care and minimal disruption to patient/provider relationships for persons with HIV that are eligible for LIHP. It is recommended to adopt the following placeholder trailer bill language to ensure these efforts are continued:

Section 15917 is added to the Welfare and Institutions Code:

(a) By no later than August 1, 2012, the State Department of Public Health, in collaboration with the State Department of Health Care Services, shall provide guidance on the transfer of clients living with HIV/AIDS from Ryan White funded programs to the Low Income Health Program (LIHP). This guidance shall be provided to LIHP participating counties, providers, and clients as applicable. This guidance shall conform to the provisions of Special Terms and Conditions of the section 1115(a) California Bridge to Reform Medicaid Demonstration to provide timely access to coordinated health care services to all LIHP enrollees. The guidance shall also minimize disruption of services to clients.

(b) The State Department of Public Health together with the State Department of Health Care Services shall consult with community representatives to obtain expert advice on policy decisions regarding the transition of clients living with HIV/AIDS from Ryan White funded programs to LIHP. This consultation shall inform the creation of the guidance described in paragraph (a). The State Department of Public Health and the State Department of Health Care Services shall communicate with these representatives on how their advice is used and how final decisions were made.

This proposed language would be included within the statutory requirements for the Low Income Health Program (Sections 15909 – 15916).

Questions. The Subcommittee has requested DPH to respond to the following question.

1. Please provide a summary of DPH's efforts on this issue since March.

3. Public Health Laboratory Training Program (DOF Issue 602)

Budget Issue. The May Revision proposes to eliminate the Public Health Laboratory Training Program for a savings of $2.2 million General Fund.

This program provides local assistance grants to subsidize training, support, outreach and education, and provides funding for doctoral candidate stipends and post-doctoral fellowships for individuals training for public health laboratory directorships.

Fifteen individuals currently participate in this program:

- Assistant Laboratory Directors (4) – These individuals are currently obtaining required supervisory and management experience and are within two years of completing the multiyear program and then obtaining a job in a California local health jurisdiction as a Lab Director.

- Post-doctoral Fellows (6) - This group has completed their PhD and are enrolled in a post-doctoral fellowship program. They are currently employed at the DPH Microbial Disease Lab or the L.A. County Public Health Lab. They are in the process of obtaining board certification. After post-doctoral training, the subsequent two years will be gaining management experience as Assistant Lab Directors (above).

- Doctoral Students (5) - These students are several years into their training and have agreed to work for several years in a public health setting after completion of their training.

Background. There are 36 local public health labs in California. Public health lab directors must meet state and federal requirements to run a lab that tests human specimens as well as have the leadership and public health training needed to oversee the functions of a laboratory that protect the health of the public. Federal law (the Clinical Laboratory Improvement Amendments of 1991) requires that public health lab directors have a doctoral degree, national board certification, and four years of supervisory experience post-doctorate. (Lab directors that were in place prior to 1991 that do not meet these requirements were grandfathered-in and do not need to meet these requirements.)

Subcommittee Staff Comment and Recommendation. Given the state's fiscal situation, it is recommended to approve this proposal. It is also recommended to adopt placeholder language to encourage the department to seek foundation support and to work with the local health jurisdictions on alternative funding sources for this program.

Questions. The Subcommittee has requested DPH to respond to the following questions:

1. Please provide an overview of this proposal.

2. Has the department explored alternative funding sources for this program?

4. Close Southern California Laboratory

Budget Issues. The DPH proposes to close its Southern California Laboratory (Temple Street building) due to health and safety concerns related to the building's code and seismic deficiencies. The closure of the Temple Street building would generate savings of $180,000 ($57,000 General Fund) in 2012-13 and $360,000 ($114,000 General Fund) in future years from various funds. DPH programs would transition out of the building on July 1, 2012.

There are currently eight DPH positions working at this location (six scientists and two support positions). DPH has indicated that it is working with these employees to find other state positions in southern California or to relocate them to the Richmond Laboratory.

Background. The DPH owns and operates two laboratory/office buildings: one in Northern California (the Richmond Laboratory) and one in Southern California (the Temple Street building). In 1988, the Department of Health Services (now DPH) purchased the Temple Street building for $1.3 million. Four DPH programs occupied this building at the time: the Environmental Laboratory Accreditation Program; the Environmental Management Branch; the Food and Drug Branch; and the Drinking Water Radiation Laboratory Branch.

Remaining Programs at Temple Street Building. Since 2009, DPH has been systematically relocating DPH programs out of the Temple Street building to other DPH space throughout southern California. Currently, the Drinking Water Radiation Laboratory Branch (DWRLB) is the only remaining DPH program in this building. In addition, DPH leases space to the Department of Toxic Substance Control's (DTSC) Environmental Health Laboratory Program.

Deficiencies with Temple Street Building. Three separate infrastructure studies of the Temple Street building have been conducted. The first two studies, completed in 1986 and 1991, identified numerous deficiencies and determined that the building did not meet various building standards. The third study, conducted in 2006, concluded that it would not be cost-effective to renovate the existing building given its many structural deficiencies.

Additionally, both DPH and DTSC have received health and safety complaints from employees and grievances from the California Association of Professional Scientists. Since 2009, DPH has been systematically relocating DPH programs out of the Temple Street building into other DPH space in Southern California.

To address the issues with the Temple Street building, DPH evaluated the following options:

- **Retrofitting Temple Street Building.** In 2006, the Department of General Services (DGS) contracted with a firm to evaluate the most cost effective method to address the Temple Street building's deficiencies. The firm concluded that given the numerous structural deficiencies retrofitting was not a viable option and that constructing a new lab at another location was a better option.
- **Construction of New Laboratory.** In 2006, DGS provided DPH with a $100 million cost estimate to acquire another property and construct a new laboratory facility. Given the state's fiscal constraints, this was not a feasible option.

- **Lease Laboratory Space.** In 2008, DPH engaged DGS to lease laboratory space in the private real estate market. While there were available properties, the estimated costs for tenant improvements (to turn the property into a lab) were estimated at $1.6 million General Fund with ongoing annual General Fund costs of $325,000.
- **Sublease Laboratory Space from Another Jurisdiction.** DPH also explored the option to sublease lab space from other jurisdictions within Los Angeles County. However, due to a lack of available space, security issues, and potential conflict of interest between DPH's oversight role of local drinking water programs, this was not an option.

Subcommittee Staff Comment and Recommendation—Approve. Although concerns have been raised that the eight employees may not find the exact state job in southern California, given the health and safety risks posed by this building, it is recommended to approve this item. Additionally, given the costs to open a new lab in southern California (i.e., rent a location and make tenant improvements), staff concurs with the department's efforts to consolidate this lab's functions with the Richmond lab and other DPH labs in southern California (e.g., the Drinking Water Program's lab in Glendale).

Finally, given that the DWRLB is a reference laboratory, the need to perform time-sensitive water testing for water systems is very minimal. DPH plans for overnight shipments of samples from southern California to the Richmond Laboratory. Moreover, in cases of emergency events, DPH has already established agreements with local laboratories for laboratory emergency response purposes and the Richmond Laboratory maintains a portable laboratory that can be mobilized as needed to respond to any emergency event throughout the state.

De-commissioning costs for the Temple Street building are not yet know and cannot be determined until all occupants are out of the building. (It is anticipated that DTSC might need up to one year to vacate the premises.)

Questions. The Subcommittee has requested DPH to respond to the following questions:

1. Please provide an overview of this proposal.

2. Please discuss the department's efforts in regards to working with the individuals employed at the Temple Street building to find other state jobs in southern California or relocating to the Richmond Laboratory.

5. Biomonitoring Fund Shifts

Budget Issue. The DPH requests a fund shift to support the California Environmental Contaminant Biomonitoring Program (CECBP). Currently, all eight DPH CECBP positions are funded by the Toxic Substances Control Account (TSCA). This request would result in two positions being supported by TSCA and six positions being supported by the Birth Defects Monitoring Program Fund, Air Pollution Control Fund, Department of Pesticide Regulation Fund, and the Childhood Lead Poisoning Prevention Fund.

Table: Proposed Funding for Biomonitoring Program

Fund	Amount
Toxic Substances Control Account	$242,000
Birth Defects Monitoring Program Fund	$240,000
Childhood Lead Poisoning Prevention Fund	$240,000
Department of Pesticide Regulation Fund	$205,000
Air Pollution Control Fund	$204,000

This request is being made as TSCA (a Department of Toxic Substances Control account) does not have sufficient revenues to support the fund's projected expenditure authority.

Rationale for Special Funds. The Administration has provided the following rationale for the use of these special funds for this program.

- **Birth Defects Monitoring Program Fund.** The causes of most birth defects remain unknown. The Birth Defects Monitoring Program was established to provide information on the incidence and trends of birth defects, stillbirths, and miscarriages, and data on whether these adverse reproductive outcomes are associated with environmental hazards, as well as to develop appropriate prevention strategies. Biomonitoring can detect chemicals capable of causing birth defects and impaired fetal development and, thus, inform public health and environmental policies to reduce such exposures, and also help focus etiologic research by university and government scientists.

  CECBP measures toxic chemical levels in people, including pregnant women and fetuses (i.e., in umbilical cord blood). A principal focus of the CECBP has been on chemicals in consumer products, some of which are currently regulated and others not. Ultimately, CECBP data will help shape California regulatory programs intended to reduce exposures to fetotoxic chemicals.

- **Childhood Lead Poisoning Prevention Fund.** The Childhood Lead Poisoning and Prevention Program (CLPPP) is a comprehensive approach to identify occurrences of high blood lead levels and reduce excessive lead exposures in children. Blood testing is the only method to quantitatively determine health risks of lead exposure. CLPPF already provides support to the Department of Public Health (DPH) Environmental Health Laboratory (EHL) for lead testing. EHL staff currently: (a) provide reference blood lead analyses for confirmatory testing of children with clinical lead

poisoning; (b) perform lead analyses of environmental samples (e.g., paint chips, dirt, toys, etc.) for case investigations and management; (c) certify proficiency of clinical laboratories; (d) serve as technical experts on current and emerging testing methods; and (e) ensure quality assurance. The additional resources to be provided to CECBP will support core CLPPP activities by offering enhanced surveillance on the prevalence, risk factors, and geographic occurrence of high childhood blood lead levels, and identifying populations where childhood lead exposures are especially significant. EHL can test all CECBP samples collected (from infants, children and pregnant women) for lead. These results will offer community-based and population-based surveillance data to augment clinic-based screening, among several other enhancements to the CLPP.

- **Air Pollution Control Fund and Department of Pesticide Regulation Fund.** The Air Pollution Control Fund (APCF) and the Department of Pesticide Regulation Fund (DPRF) primarily support the broad spectrum of regulatory and other activities of the Air Resources Board (ARB) and the Department of Pesticide Regulation (DPR), respectively. Both ARB and DPR include among their responsibilities assessing exposure to air pollutants and pesticides, and educating the public about such exposures.

  The CECBP objectives include measuring and tracking trends in human exposure to chemicals and making this information public in summary form, which can help inform environmental regulatory policies. The CECBP "designated" and "priority" chemicals comprise a variety of air pollutants and pesticides. Among the air pollutants are metals (e.g., antimony, arsenic, lead, and mercury), volatile organic chemicals, diesel exhaust, and polycyclic aromatic hydrocarbons (PAHs). Also included are cyclosiloxanes, which have been introduced statewide in dry cleaning establishments as perchloroethylene has been phased out to comply with an ARB regulation. All major pesticide classes or their metabolites are within the CECBP universe of chemicals to measure, including organophosphates, carbamates, pyrethroids, and fungicides. The DPH EHL is currently measuring PAHs, metals, and multiple classes of pesticides in blood and urine specimens from biomonitoring participants. Over time, the CECBP will be developing additional advanced laboratory methods to measure other air pollutants and pesticides. This information can help inform the ongoing efforts of the ARB and DPR to assess and regulate human exposure to the chemicals under their jurisdictions, providing a logical nexus between the CECBP and both the APCF and the DPRF.

Background. The CECBP was established by SB 1379 (Perata), Statutes of 2006. The legislation provides for DPH, the Office of Health Hazard Assessment, and the Department of Toxic Substances Control to conduct the program collaboratively, with DPH as the lead entity. The program's overall purpose is to measure and track levels of environmental chemicals in California residents as a way to inform policy makers and to alert them to the presence and associated health risk of chemicals in the environment, home, and workplace.

Subcommittee Staff Comment and Recommendation—Approve. It is recommended to approve this proposal. The Administration has identified appropriate fund sources to support the California Environmental Contaminant Biomonitoring Program.

Questions. The Subcommittee has requested DPH to respond to the following question:

1. Please provide an overview of this proposal.

2. Please provide a status update of the biomonitoring summary report that is to be completed by July 2012.

B. 4280 Managed Risk Medical Insurance Board

1. Healthy Families Program Caseload Update (DOF Issue 102, 103, 104, 111, 112)

Overview. In the May Revision, MRMIB estimates that if no HFP children are transferred to Medi-Cal, the projected caseload for HFP is 878,112. This is an increase of 5,185 children over the current year, and represents a 0.6 percent annual growth rate over the current year.

Funding for the full HFP caseload (878,112) for 2012-13 would be $1.1 billion ($381.7 million General Fund, $727.5 million federal funds, $8.1 million in reimbursements, and $8.7 million from the Children's Health and Human Services Fund).

The average benefit cost per month per eligible member under HFP is $101.77.

The May Revision also reflects an increase in General Fund due to HFP enrollees selecting higher cost plans and increased program expenditures due to wraparound payments to Federally Qualified Health Centers and Rural Health Clinics.

Copayment and Premium Increases Savings Erosion. Additionally, MRMIB requests an increase of $22.8 million General Fund and $42.4 million in federal funds to reflect the full year erosion of budget year savings previously adopted by the Legislature related to premiums and copayments for the Healthy Families Program (HFP).

The Governor' January budget assumed premiums would have increased by $14 per child for children in families with income between 200 percent and 250 percent of the federal poverty level (FPL) and by $18 per child for children in families with income between 200 percent and 250 percent of FPL. However, the federal government has indicated that this increase would be a violation of the state's maintenance of effort requirements imposed by federal health care reform.

The Governor's January budget also assumed increased copayments for emergency room visits from $15 to $50. However, in the May Revision, the Administration has altered this proposal to assume only $15 for non-emergency visits to the emergency room. Since HFP plans already impose an emergency room copayment of $15, there are no longer savings attributable to this proposal.

Managed Care Organization Tax – Technical Adjustment. Finally it should be noted that May Revision reflects an increase of $2.6 million General Fund as a result of a reduction of managed care organization (MCO) tax revenue carryover from the current year.

LAO Comment. Based on its analysis of HFP enrollment data, the LAO finds that the Governor's projection of continued flat enrollment into HFP is reasonable.

Subcommittee Staff Comment & Recommendation—Approve. It is recommended to approve the adjustments to funding for HFP, with any changes to conform as appropriate to other actions that have been or will be taken.

Questions. The Subcommittee has requested MRMIB to respond to the following questions:

1. Please provide an update on the HFP caseload and growth trend.

2. Transition of Healthy Families Children to Medi-Cal – MRMIB and DHCS

Budget Issue. In the January budget, the Governor proposed to:

- Shift *all* Healthy Families Program (HFP) children into Medi-Cal over a nine-month period beginning in October 2012. Approximately 878,000 eligible enrollees would move to Medi-Cal in phases between October 2011 and June 2013.
- Require the Managed Risk Medical Insurance Board (MRMIB) to negotiate managed care health plan capitation rates for children receiving health care services in the Healthy Families Program (HFP) at a statewide weighted average capitation rate that is less than or equal to the statewide average capitation rate established by the Department of Health Care Services for health benefits for children up to age 19 in the Medi-Cal program.

Estimated Savings. In the May Revision, the Administration updates its estimates on this transition and rate reduction and estimates that these proposals would result in total savings of $48.6 million General Fund savings (the January estimate was $64.4 million General Fund savings). Since under the May Revision the Administration estimates that the average per-member per-month cost of a Medi-Cal enrollee increased from $76.86 to $83.81, the Administration's January proposed savings were reduced under the May Revision. This new rate includes additional Medi-Cal administrative costs and accounts for mental health benefits that are carved out of the Medi-Cal managed care rate.

Dental Managed Care. Additionally, it should be noted that the Administration's proposal included the expansion of Medi-Cal Dental Managed Care as the individuals enrolled in an HFP dental plan would transition to the same dental plan to the extent that the plan is a Medi-Cal dental managed care plan. If the enrollee's HFP dental plan is not a Medi-Cal dental managed care plan, DHCS would be authorized to contract with the dental plan to allow the individuals to enroll in the same plan. These new dental health plans will also be available for voluntary enrollment by existing Medi-Cal enrollees.

Proposed Benefits of Transition. The Administration finds that the key benefits of this consolidation of HFP and Medi-Cal would be the following:

- Enrollment for children would be simplified with a unified program of coverage for all eligibles up to 250 percent of FPL;
- Families would be able to apply for coverage at a county, by mail, or on-line and will not have to have their application bounced between programs;
- Children at or below 150 percent of FPL would no longer pay premiums, as is presently done in the Healthy Families Program;
- Children would receive retroactive coverage for three-months *prior* to their application;
- Children would be eligible for the free federal Vaccines for Children (0 to 18 years);
- Makes available to low-income children comprehensive Medi-Cal services including Early and Periodic, Screening, Diagnosis and Treatment (EPSDT) Program;

- Many children would be able to remain with their existing provider during the transition as Health Plans contract with providers for both Medi-Cal and Healthy Families. It is estimated that 78 percent of children in Healthy Families match to a health plan that currently participates in both Medi-Cal and Healthy Families (either via a contract or subcontract, Phase 1 and Phase 2A);
- There has been a considerable decline in the commercial health plans participating in Healthy Families in many counties. By consolidating Healthy Families and Medi-Cal, children will have more stable plan choices;
- Consolidates health care entitlement programs under one department so that duplicative systems and processes can be eliminated to gain administrative efficiencies;
- Simplifies contracting requirements, rates and other core components of delivering services in the public sector for health plans and providers;
- Increases the ability of the state to monitor encounter data and payment data to better ensure the state is receiving its best value for the dollars it invests in children's coverage;
- Serves as an early building block for successful implementation of federal health care reform. California must implement many changes before 2014, including new online enrollment processes, new eligibility rules, an expansion of coverage, and the development of the Health Benefit Exchange. Under health care reform, HFP children with incomes under 133 percent of FPL would become Medi-Cal enrollees on January 1, 2014.

Subcommittee Staff Comment and Recommendation. It is recommended to (1) reject the Administration's proposed shift of all HFP children to Medi-Cal, (2) reject the expansion of Medi-Cal Dental Managed Care, and (3) reject the trailer bill language requiring MRMIB to reduce HFP rates.

Instead, it is recommended to adopt placeholder trailer bill language to shift HFP children with incomes under 133 percent of the federal poverty level (or in families with Modified Adjusted Gross Income under 138 percent of the federal poverty level) to Medi-Cal beginning October 2012. This recommendation is consistent with federal ACA, as HFP children with incomes under 133 percent of FPL would become Medi-Cal beneficiaries on January 1, 2014.

These HFP children would be shifted to Medi-Cal in phases (see table below) in an effort to address provider continuity.

Table: Transition of HFP Children to Medi-Cal

Phase	Impacted Enrollees	Eligibles	Phase-In Period
1	HFP children with a "matching" Medi-Cal managed care plan	88,232	October – December 2012
2A	HFP children in a plan that subcontracts for Medi-Cal managed care	54,164	January – March 2013
2B	HFP children in a managed care plan that does not contract or subcontract with Medi-Cal	36,429	March - May 2013
3	HFP children in fee-for-service	7,632	June 2013
	TOTAL Children	186,457	

Note: This table does not reflect a growth in the HFP caseload and was a point-in-time estimate.

It is also recommended to adopt placeholder trailer bill language to facilitate the transition of children to appropriate dental services, whether it is Fee-for-Service Medi-Cal or a continuation in existing dental managed care arrangements in Los Angeles and Sacramento counties.

This recommendation results in $27.3 million ($10.8 million General Fund) savings.

Questions. The Subcommittee has requested the Administration to respond to the following questions:

1. Please provide an overview of the Administration's updated proposal.

2. How has the Administration worked with stakeholders since January on identifying and addressing key issues regarding the transition of HFP children to Medi-Cal?

3. Transfer of MRMIB Programs to the Department of Health Care Services

Budget Issue. The administration proposes trailer bill language to eliminate MRMIB and transfer its programs to DHCS. Specifically, the Healthy Families Program would transfer to DHCS beginning October 2012. The remaining programs, the County Children's Health Initiative Program; Access for Infants and Mothers; Major Risk Medical Insurance Program; and Pre-Existing Conditions Insurance Plan would transfer to DHCS effective July 1, 2013.

Subcommittee Staff Comment and Recommendation–Reject. It is recommended to reject this proposal. Given the recommendation to reject the Administration's proposal to shift the entire HFP program to Medi-Cal, MRMIB will continue to oversee HFP as well as other programs.

Questions. The Subcommittee has requested the Administration to answer the following questions:

1. Please provide an overview for this proposal and a discussion of the Administration's rationale for eliminating MRMIB.

C. 4150 Department of Managed Health Care

1. DMHC's Role in Coordinated Care Initiative (DOF Issue 103)

Budget Issue. In the May Revision, DMHC requests 13 positions and $1.1 million (Managed Care Fund), including $77,500 for consultant services, to address the new workload attributable to the evaluation of plan readiness and oversight of health plans for the Governor's Coordinated Care Initiative.

The requested positions are:

- **Help Center – 8 positions** (These positions would begin January 1, 2013.)
    - 1 Health Program Specialist II
    - 1 Nurse Evaluator II
    - 1 Associate Governmental Program Analyst
    - 5 Consumer Assistance Technicians

  These positions would respond to consumer phone calls and correspondence, resolve complaints, and develop technical assistance guides for medical surveys.

- **Division of Licensing – 4 positions** (These positions would begin July 1, 2012.)
    - 2 Staff Counsels
    - 1 Health Program Specialist
    - 1 Associate Health Program Adviser

  These positions would review health care service plan filings for compliance with statutory, regulatory, and contract requirements, conduct network adequacy assessments, and review utilization patterns.

- **Division of Financial Oversight – 1 position** (This position would begin July 1, 2012.)
    - 1 Corporation Examiner

  This position would perform financial analysis and review of materials submitted with health care service plan filings. This analysis includes a review of fiscal viability impacts.

In addition, DMHC will utilize a medical consultant to prepare for the medical surveys and to conduct the anticipated 25 Independent Medical Reviews generated by the dual eligibles enrolling in managed care plans.

The DMHC anticipates submitting a 2013-14 proposal to request additional positions as permanent resources to handle the ongoing workload.

Background. The Governor's budget and May Revision includes a Coordinated Care Initiative for Medi-Cal enrollees. The Coordinated Care Initiative would expand the enrollment of dual eligibles into Medi-Cal managed care from the four demonstration pilots (as provided under SB 208, Statutes of 2010) to up to 8 counties in 2013 and statewide by 2015 and integrate home- and community-based long-term supports and services (LTSS) into Medi-Cal managed care for Medi-Cal enrollees in up to 8 counties in 2013 and statewide by 2015.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open as discussions continue related to the Coordinated Care Initiative.

Questions. The Subcommittee has requested DMHC to respond to the following questions:

1. Please provide an overview of this proposal.

2. Please describe what new factors would be included in the survey.

2. Medi-Cal Dental Managed Care Program (DOF Issue 102)

Budget Issue. In the May Revision, the DMHC requests 3 positions and $295,000 from the Managed Care Fund to expand DMHC oversight of licensed dental managed care plans participating in the Medi-Cal Dental Managed Care (DMC) program.

DMHC intends to plan, prepare, and develop tools and documents to conduct annual financial audits and dental surveys in place of the normal three-year audit/survey schedule. These are new annual audits and surveys of nine dental managed care plans would also include a new scope of work for DMHC. For this workload, DMHC is requesting one Health Program Specialist II (effective January 1, 2013) and one Corporation Examiner (effective January 1, 2013) and $83,000 in consultant services to develop audit guides and survey tools.

Additionally, this proposal addresses the increased workload resulting from the transfer of Healthy Families Program (HFP) children to Medi-Cal and Medi-Cal Dental Managed Care, commencing on October 1, 2012. It is anticipated that there will be an increase in the number of enrollee inquiries, correspondence and complaints received by the Help Center. For this workload, DMHC requests one Staff Services Analyst.

Background. DHCS and DMHC contract with five Geographic Managed Care (GMC) Plans and eight Prepaid Health Plans (PHP) that provide dental services to Medi-Cal enrollees in Sacramento and Los Angeles counties. The DMHC licenses dental managed care plans.

No Oversight of Medi-Cal DMC Plans. In February 2012, a Sacramento Bee article describing significant access and quality of care problems in the dental GMC program in Sacramento County generated an increase of consumer complaints to DMHC's Help Center and concern about the lack of access to dental care for children in that county.

At the March 22, 2012 Subcommittee #3 hearing, this Subcommittee adopted trailer bill legislation proposed Pro Tem Senator Steinberg to increase DMHC's oversight of DMC plans. DMHC is initiating immediate investigations ("non-routine audits") of the five GMC plans in Sacramento to evaluate access to care and provider network adequacy. DMHC is absorbing this immediate workload using existing resources; however, to address these concerns on an ongoing basis and to have the resources to perform annual on-site dental surveys and financial examinations, DMHC is submitting this proposal.

Prior to non-routine audits described above, DMHC did not directly survey Medi-Cal DMC products. Additionally, DMHC did not review, assess, or evaluate the plan's performance of their Medi-Cal DMC contractual deliverables; request, review, or evaluate DMC's enrollment data, quality issues, network adequacy, language assistance, or any other potential barriers to care.

Expansion of Medi-Cal DMC. The Governor's January budget proposes to transition all HFP enrollees to Medi-Cal beginning October 1, 2012. This will result in the addition of about 875,000 HFP enrollees into the Medi-Cal dental program. It is estimated that about 387,000 of

the HFP enrollees will enroll in the Fee-For-Service (FFS) dental program and about 488,000 HFP enrollees will enroll in the Medi-Cal DMC program. This increase in the number of Medi-Cal DMC program enrollees is expected to increase DMHC's workload with respect to providing oversight of quality of care and network adequacy through dental surveys of dental plans and responding to enrollee grievances, appeals, and complaints.

Subcommittee Staff Comment and Recommendation—Approve. It is recommended to approve this proposal as the workload is justified by the new scope of work (monitoring for Medi-Cal DMC contract deliverables and a review for barriers to care) and more frequent oversight of DMC plans by DMHC.

Questions. The Subcommittee has requested DMHC to respond to the following questions.

1. Please provide an overview of this proposal.

2. Please provide an update on the current year non-routine surveys of Medi-Cal Dental Managed Care plans.

D. 0530 California Health and Human Services Agency and 4260 Department of Health Care Services

1. CalHEERS Integration with the State's Public Assistance Systems

As required by the Affordable Care Act (ACA), states must establish an insurance exchange or use a federally established exchange. California's Health Benefit Exchange (Exchange) was established by AB 1602 (Perez, Statutes of 2010) and SB 900 (Alquist, Statutes of 2010). The Exchange is an independent state that is required to facilitate the purchase of qualified health plans by individuals and small employers no later than January 1, 2014. The California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS) is the Exchange's enrollment system to purchase qualified health plans. Recently released proposed federal regulations, require coordination between Exchanges, Medicaid, and Children's Health Insurance Programs to ensure a seamless, integrated process for individuals seeking health coverage under an Exchange.

Overview of Administration's May Revision CalHEERS Proposal. The Administration has various proposals related to the California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS). The Office of Systems Integration and DHCS proposals are discussed below. The Department of Social Services also requests budget bill language and expenditure authority. This request will be discussed at the Subcommittee #3 hearing on May 22, 2012.

a. Office of Systems Integration – Request for Project Management Staff

Budget Issue. In the May Revise, the Administration requests trailer bill language, budget bill language, and 16 limited-term positions for its Office of Systems Integration (OSI) to provide project management services for the CalHEERS Project (and the corresponding reimbursement authority from the California Health Benefit Exchange). These costs ($2.5 million) will be reimbursed by the Health Benefit Exchange Board.

Trailer Bill Language. OSI requests trailer bill language to provide OSI the authority to provide project management of the CalHEERS Project.

Budget Bill Language. OSI requests budget bill language to allow expenditure of funds upon approval of DOF and notification to the Joint Legislative Budget Committee and to allow DOF to augment the OSI budget to accommodate increased funding provided by the California Health Benefit Exchange. The following budget bill language is requested for 0530-001-9732:

Provisions:

X. Of the funds appropriated in this item, $2,543,000 is to support the system changes necessary to implement federal health care reform. These funds are not authorized for expenditure under approved by the Director of the Department of Finance. The Director of Finance shall provide notification in writing to the Joint Legislative Budget Committee of any

expenditure approved under this provision not less than 60 days prior to the effective date of the approval. This 60-day notification shall include a plan for the system changes necessary to implement the requirements of the federal Affordable Care Act.

X. The Director of Finance is authorized to approve current year increases in the Office of System's Integration's expenditure authority to accommodate increases in funding provided by the California Health Benefit Exchange for services related to the California Healthcare Eligibility, Enrollment, and Retention System project. Any such increases shall occur no sooner than 30 days after notification in writing of the necessity therefor to the Joint Legislative Budget Committee, or not sooner than whatever lesser time after notification the chairperson of the Joint Legislative Budget Committee, or his or her designee, may in each instance determine.

Positions. According to the Administration, the request for staff is consistent with that of other large scale IT projects which OSI has been involved in implementing, and includes the following positions:

1. Project Director (Exempt) - Oversees the development and implementation of the CalHEERS Project, providing leadership and strategic direction to the CalHEERS Project to ensure organizational objectives are achieved. Plans, directs and oversees the project to ensure deliverables and functionality are achieved.

2. Assistant Project Director (DPM IV) - Assists the Project Director in overseeing all aspects of the CalHEERS Project. Directs and oversees staff responsible for oversight of the CalHEERS project design, development, and implementation.

3. Project Management Services Manager (DPM III) - Plans and directs the activities of the CalHEERS Project Administrative and Project Management Support Teams. This position is responsible for defining and managing administrative support functions such as procurement, contract, and financial management and is also responsible for overseeing the prime vendor's project management office. Provides general leadership and supervision to the CalHEERS Project Administration and Project Management Support units.

4. Project Support Analyst (Sr. ISA) - Plans, organizes, coordinates and manages a variety of the most complex activities and services. Will oversee the tracking of the Prime Contractor and consultant contract deliverables for the project. Also oversees the monitoring of contract compliance, participates in negotiations, facilitates amendments, and reviews work authorizations and invoices. Also, responsible for tracking and coordinating deliverable approvals.

5. Project Support Analyst (Sr. ISA) - Plans, organizes, coordinates and manages a variety of the most complex activities and services. Will oversee the tracking of the prime contractor and consultant contract deliverables for the project. Also oversees the monitoring of contract compliance, participates in negotiations, facilitates amendments, and reviews work authorizations and invoices. Also responsible for tracking and coordinating deliverable approvals.

6. Procurement/Contract Analyst (Sr. ISA) - Responsible for development of plans and procedures for all CalHEERS Project IT contracts, and associated deliverables, materials, etc. Ensures contractual obligations are met and provides continual review to ensure that all terms and conditions are in compliance. Also responsible for directing, preparing, and reviewing the most complex IT and non-IT competitive procurements, ensuring adherence to state laws and regulations, Executive Orders, Administrative Orders, and Management Memos.

7. Financial Analyst (Sr.ISA) - Responsible for managing and tracking project budget/costs and for performing financial tasks following federal and state laws, regulations, and guidelines related to the project's fiscal responsibilities.

8. System Development Support and Implementation Manager (DPM III) - Plans, organizes and directs all the activities of the CalHEERS Application Development and Technical Architecture teams which include both state and consultant staff. Works in partnership with stakeholders to ensure all program and technical needs are defined and reflected in the design, development, and implementation of the CalHEERS solution.

9. Application Development Lead (Sr. ISA) - Ensures the business requirements and functionality of the CalHEERS solution meets the needs of the Health Benefit Exchange, Department of Health Care Services, the Managed Risk Medical Insurance Board, and other program stakeholders.

10. Interface Management (Sr. ISA) - Provides leadership and oversight for interface activities, in coordination with the Systems Integrator. Oversees stakeholder management and coordination, identifies risks, and utilizes findings in developing mitigation strategies.

11. UAT Testing (Sr. ISA) - Supports preparation of test plans, test scenarios and test transactions to be executed by State, county, and other stakeholder staff. Reviews test results from contractor testing and State, county, and other stakeholder staff testing. Provides comments, recommendations and other input directed at error correction, risk management and quality assurance.

12. Organization Change Manager (Sr. ISA) - Executes activities related to change management frameworks. Carries out activities required for project team engagement, organizational readiness, stakeholder management, training classes, communication activities, and leadership alignment. Builds change management capability with the project team and stakeholder deployment teams.

13. Technical Architecture (SSS III) - Technical specialist who is responsible for ensuring the CalHEERS Project architecture fits within the CalHEERS project requirements, the State's overall architecture strategy and meets the needs of the state, counties, and other stakeholders.

14. Executive Assistant (EA) - Provides assistance to the Project Director and project management staff by conducting analytical research on sensitive program issues,

responding to inquiries, ensuring timely and accurate delivery of products and ensuring the accurate development and release of sensitive and confidential communications. Assists with travel, schedules, and all logistics of high-level meetings.

15. Agency Information Officer Health Information Technology Liaison (Sr. ISA) - Facilitates the development of the CHHSA governance structure consistent with CalHEERS, Health Information Exchange, and Health Information Technology governance structures to effectively leverage the SOA architecture and processes that will be built as part of CalHEERS.

16. SAWS Liaison (DPM III) – Supports the CalHEERS Project in the areas of interface management, issue and risk management, and project governance. Recommends changes to draft deliverables and approval or disapproval of final deliverable documents. Participates in strategic and tactical planning and maintains principles for OSI and project sponsor decision-making on issues with multi-departmental and statewide impact.

b. Department of Health Care Services – Medi-Cal & CalHEERS Integration (DOF Issue 112)

Budget Issue. In the May Revision, the DHCS requests the following related to CalHEERS:

- Budget bill language to allow expenditure of funds to implement CalHEERS.
- The establishment of 12 two-year limited-term positions, effective October 1, 2012, to support the planning, design, development, implementation, and ongoing maintenance of the Medi-Cal eligibility and enrollment system changes and integration with CalHEERS and county eligibility consortia systems.
- Funding to implement changes to the MEDS system for CalHEERS.
- Funding for the Medi-Cal's portion of the state's costs for CalHEERS.

Table: DHCS Funding Requests Related to CalHEERS

Purpose	Federal Funds	General Fund	Total Funds
Establish 12 positions for Medi-Cal eligibility changes and CalHEERS integration	$1,000,000	$224,000	$1,224,000
MEDS changes and interfaces with CalHEERS	1,446,300	160,700	1,607,000
Medi-Cal's associated costs for CalHEERS development	9,421,200	1,046,800	10,468,000
Total	$11,867,500	$1,431,500	$13,299,000

Budget Bill Language. DHCS requests budget bill language to allow expenditure of funds upon approval of DOF and notification to the Joint Legislative Budget Committee (JLBC) and to allow DOF to augment DHCS' expenditure authority in order to implement of CalHEERS upon notification to JLBC (this notification would include a plan for the expenditures). The following budget bill language is requested:

A Budget Bill Language to Item 4260-001-0001

Provisions:

X. Of the funds appropriated in this Item, $224,000 is to support the system changes necessary to implement federal health care reform. Notwithstanding Provision 2 of this item, these funds are not authorized for expenditure until approved by the Director of Finance. The Director of Finance shall provide notification in writing to the Joint Legislative Budget Committee of any expenditure approved under this provision not less than 60 days prior to the effective date of the approval. This 60-day notification shall include a plan for the system changes necessary to implement the requirements of the federal Affordable Care Act.

Add Budget Bill Language to Item 4260-101-0001

Provisions:

X Of the funds appropriated in this Item, $1,206,000 is to support the system changes necessary to implement federal health care reform. These funds are not authorized for expenditure until approved by the Director of Finance. The Director of Finance shall provide notification in writing to the Joint Legislative Budget Committee of any expenditure approved under this provision not less than 60 days prior to the effective date of the approval. This 60-day notification shall include a plan for the system changes necessary to implement the requirements of the federal Affordable Care Act.

X. The Director of Finance is authorized to approve current year increases in this item for expenditures necessary for implementation of the California Healthcare Eligibility, Enrollment and Retention System project. The Director of Finance shall provide notification in writing to the Joint Legislative Budget Committee of any expenditure approved under this provision not less than 60 days prior to the effective date of the approval. This 60-day notification shall include a plan for the system changes necessary to implement the requirements of the federal Affordable Care Act.

Positions. As part of this proposal, DHCS requests the following positions:

- The Medi-Cal Eligibility Division is requesting three two-year limited-term positions to support the planning, development, implementation, and evaluation of Medicaid eligibility rules and enrollment simplification provisions as required by federal health care reform. These positions are eligible for the regular administrative federal financial participation (FFP) rate of 50 percent.
- The Information Technology Services Division is requesting nine two-year limited-term positions to support the planning, design, development, implementation, and ongoing maintenance of the Medi-Cal eligibility enrollment system changes and integration with CalHEERS and county eligibility consortia systems. These positions are eligible for enhanced FFP at a rate of 90 percent through December 31, 2015. Beginning January 1, 2016, these positions are eligible for 75 percent FFP rate for on-going maintenance and operations of the new system components.

MEDS Changes. The DHCS requests $1,446,300 ($160,700 General Fund) to implement changes to the MEDS system for CalHEERS. The MEDS system is the statewide database which includes eligibility information for Medi-Cal, CalWORKs, and CalFRESH. It will be necessary to interface between MEDS and CalHEERS. The state will receive enhanced federal funding (90 percent federal participation) for these changes.

Medi-Cal's Share of Funding for CalHEERS Project. The DHCS requests $10.5 million ($1 million General Fund) to support Medi-Cal's share of the costs to implement CalHEERS. Medi-Cal's associated costs for the development and implementation of CalHEERS is 17 percent (of the state's 10 percent).

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open as discussions continue on the CalHEERS Project.

Questions. The Subcommittee has requested the Administration to respond to the following questions:

1. Please provide an overview of these proposals and discuss why the Administration is requesting such broad authority for future expenditures.

2. What is the overall goal of the CalHEERS Project?

3. What will be the role of each state department?

E. 4260 Department of Health Care Services

Medi-Cal Caseload and Budget – May Revision Update – Informational Item

The federal Medicaid Program (Medi-Cal in California) provides medical benefits to low-income individuals who have no medical insurance or inadequate medical insurance.

Medi-Cal is at least three programs in one: (1) a source of traditional health insurance coverage for low-income children and some of their parents; (2) a payer for a complex set of acute and long-term care services for the frail elderly and people with developmental disabilities and mental illness; and (3) a wrap-around coverage for low-income Medicare recipients ("dual" eligibles who receive Medicare and Medi-Cal services).

Governor's May Revision. The May Revision proposes total expenditures of $59.7 billion ($14.4 billion General Fund) for 2012-13 which represents *an increase* of $12.8 billion (total funds), or 27.4 percent more than the current-year.

Medi-Cal caseload is projected to be 8,246,300, which represents a 7.9 percent increase compared to current year (and reflects the full transition of HFP children into Medi-Cal).

Table: Medi-Cal Funding Summary (dollars in millions)

	2011-12 Revised	2012-13 Proposed	Difference	Percent
Benefits	$43,917.9	$56,282.6	$12,364.7	28.2%
County Administration (Eligibility)	2,630.1	3,072.0	441.9	16.8%
Fiscal Intermediaries (Claims Processing)	318.9	350.5	31.6	9.9%
Total-Local Assistance	**$46,866.9**	**$59,705.1**	**$12,838.2**	27.4%
General Fund	$15,460.9	$14,405.6	-$1,055.3	-6.8%
Federal Funds	$28,663.0	$36,242.0	$7,579.0	26.4%
Other Funds	$2,743.0	$9,057.0	$6,314.0	230.2%

LAO Comment. Based on its review of recent caseload data, the LAO finds that the Administration's revised estimates of Medi-Cal caseload are reasonable. The majority of the caseload changes reflect lower caseload for families with children enrolled in Medi-Cal. On average, individuals who are included in these eligibility categories are some of the least expensive Medi-Cal beneficiaries.

1. Eliminate Gross Premium Tax Sunset Date for Medi-Cal Managed Care Plans

Budget Issue. The Administration proposes trailer bill language that eliminates the sunset date for the existing gross premiums tax (GPT) imposed on Medi-Cal managed care plans. In the May Revision, the Administration estimates that this will generate $188.4 million in General Fund savings in 2012-13.

The GPT is expected to generate about $376 million in revenues. Half of the revenues, or about $188 million, will be matched with federal funds to provide for an increase in capitation payments to Medi-Cal managed care plans.

Table: Gross Premium Fund Transfer to the General Fund (in millions)

Gross Premium Tax Applications	
Base Medi-Cal Managed Care Program	$138.3
SB 335 - Hospital Fee	31.2
2012-13 Budget Proposals	
Coordinated Care Initiative	$12.9
Healthy Families Program Transition to Medi-Cal*	4.3
FQHC Payment Reform*	1.5
Total	**$188.4***

*It should be noted that this Subcommittee rejected the Administration's proposal for FQHC Payment Reform; consequently, the General Fund offset would be reduced by this amount. Additionally, as discussed earlier in this agenda, it is recommended that only a portion of Healthy Families Program children be transitioned to Medi-Cal, this would result in a reduction to the above estimated General Fund offset.

(Please note that there is a managed care organization tax technical adjustment to the Healthy Families Program listed under the MRMIB section of this agenda.)

Subcommittee Staff Comment and Recommendation. It is recommended to:

- Reject the Administration's trailer bill language to eliminate the sunset date for the GPT.
- Adopt placeholder trailer bill language that extends the GPT sunset date for two years.

Questions. The Subcommittee has requested DHCS to respond to the following question:

1. Please provide a summary of this proposal.

2. Non-Emergency ER and Prescription Drug Copay (DOF Issue 121)

Budget Issue. The May Revision proposes to increase General Fund expenditures by $555 million due to an erosion of savings from mandatory copayments for Medi-Cal services, pursuant to AB 97 (Statutes of 2011) that were not implemented because the state did not receive federal CMS approval.

Revised Non-Emergency ER Copay. Additionally, DHCS is proposing legislation to implement a $15 copayment for non-emergency use of the emergency room (ER). AB 97 implemented a mandatory copayment of $50 for non-emergency room use of the ER. Pending approval from the federal CMS, this copayment would be implemented in the managed care setting and would not apply to those who are in the Family Planning, Access, Care, and Treatment program. The hospital would collect the $15 copayment from enrollees at the time of service, and the hospital would be reimbursed the appropriate Medi-Cal reimbursement rate minus the $15 copayment. This copay would result in $7.1 million General Fund savings in the budget year.

Pharmacy Copay. Finally, DHCS is proposing legislation to implement a $3.10 copay for non-preferred drugs. AB 97 implemented a mandatory copay of $3 per prescription for preferred drugs and a $5 per prescription for non-preferred drugs. Pending approval from the federal CMS, this copayment would be implemented in the managed care setting and would not apply to those who are in the Family Planning, Access, Care, and Treatment program. The pharmacy would collect the $3.10 copayment from enrollees at the time of service, and the pharmacy would be reimbursed the appropriate Medi-Cal reimbursement rate minus the $3.10 copayment. This copay would result in $13.1 million General Fund savings in the budget year.

The DHCS estimates that both these copays would be implemented January 1, 2013.

Subcommittee Staff Comment and Recommendation—Approve. The DHCS is not able to implement the copays required by AB 97 because it did not receive federal approval. It is recommended that the Medi-Cal estimate reflect this savings erosion. Additionally, it is recommended to approve the Administration's proposed non-emergency room ER and pharmacy copay.

Questions. The Subcommittee has requested DHCS to respond to the following questions.

1. Please provide a summary of this proposal.

2. Please discuss why DHCS finds that these copays would receive CMS approval.

3. County Medi-Cal Eligibility Processing

Governor's May Revision. Federal Medicaid law requires a governmental entity to finalize *all* eligibility applications. In California, County Human Services Departments serve as surrogate for the State to perform this important function.

The May Revision proposes General Fund savings of $43.1 million by not providing a cost-of-living adjustment (COLA) to the counties for a savings of $13.1 million and recognizing $30 million savings as a result of the reconciliation of 2009-10 county administrative expenditures.

Two years following the end of the fiscal year, county administration expenditures are reconciled to the county administration allocation for the applicable fiscal year. Counties have one year from the end of a quarter to amend their quality administrative claim, which is used by DHCS for its reconciliation process.

Report to Legislature on Updated Budgeting Methodology Not Provided. It should also be noted that AB 102 (Statutes of 2011) required DHCS to report to the Legislature on an updated methodology for county administrative expenditures on March 1, 2012. This report has not been received. This updated methodology was necessary for several reasons:

- The Affordable Care Act (health care reform) requires Medicaid (Medi-Cal) eligibility to transition to using "modified adjusted gross income" (MAGI) standard for making eligibility determinations for most of the population. The use of MAGI is designed to simplify eligibility determinations and to eliminate the use of asset tests for families, children, and newly eligible populations.

- The federal ACA also requires implementation of streamlined eligibility processing procedures to help facilitate the enrollment of individuals into coverage.

- The existing process for determining county administrative baselines, adding in caseload increases and making other special and technical adjustments has not been an effective method for the State or for the Counties.

Last year, DHCS stated that a new budgeting methodology would result in a simpler and more accurate budgeting of Medi-Cal eligibility processing and would provide flexibility in the future when the State adds new eligible groups pursuant to the ACA. Further it would help inform budget decisions, allow for ongoing monitoring, improve fiscal accountability and support better management and evaluation of program administration.

Subcommittee Staff Comment and Recommendation. It is recommended to approve DHCS' proposal to not include a COLA for county administration and to recognize the reconciliations collections for a General Fund savings of $43.1 million and to adopt placeholder trailer bill language to implement the COLA savings. The state has not provided a cost-of living adjustment since 2008-09 and given the state's fiscal situation it is recommended to not provide this adjustment in the budget year. It is also recommended to get an update from DHCS on its efforts to update this budgeting methodology.

Questions. The Subcommittee has requested the DHCS to respond to the following questions:

1. Please provide a summary of the DHCS' activities related to revising the county administrative cost budget methodology.

2. What is the timeline for updating this budgeting methodology?

4. Coordinated Care Initiative (DOF Issue 124)

Budget Issue. The Governor's January budget included a Coordinated Care Initiative for Medi-Cal enrollees. With this initiative, the Administration intends to improve service delivery for the 1.1 million people eligible for both Medi-Cal and Medicare (dual eligibles) and 330,000 additional Medi-Cal enrollees who rely on long-term services and supports (LTSS).

In the May Revision, the Administration proposes the following changes to its Coordinated Care Initiative:

- **Implementation date**. In response to stakeholder feedback that more time is needed to prepare for enrollment, the May Revision proposes to move the implementation date from January 1, 2013 to **March 1, 2013**. Enrollment will be phased in throughout the rest of 2013.
- **Demonstration Counties**. The number of counties proposed for demonstration implementation in 2013 has been reduced from ten to eight. The Administration has suspended work on launching the demonstration in Contra Costa and Sacramento counties for 2013, but intends to include those counties in the second year expansion.
- **Mandatory Medi-Cal Managed Care Enrollment**. The May Revision limits dual eligible mandatory enrollment in Medi-Cal managed care in 2013 to only the eight counties where the duals demonstration is implemented. Previously, the Coordinated Care Initiative proposed mandatory Medi-Cal managed care for wrap-around Medi-Cal services in all managed care counties in 2013. (This change was made in February, but the fiscal estimates have been updated in the May Revision to reflect this change.)
- **Long-Term Supports and Services.** The May Revision indicates the Administration's intention to eventually transition In-Home Supportive Services collective bargaining from the local government level to the state. This issue will be discussed at the Subcommittee#3 hearing on May 22, 2012.

Table: May Revise Coordinated Care Savings (dollars in millions)

	Total Funds	**General Fund**
Medicare Shared Savings	-$12.3	-$12.3
Long-Term Supports and Services	223.2	111.6
Defer Managed Care Payment	-1,271.1	-635.5
Delay Check-write	-150.4	-75.2
Total	**-$1,210.6**	**-$611.5**

It should be noted that detailed estimates on the May Revision savings are not available. However, the Administration indicates that the revised Medicare Shared Savings reflects a delay in the implementation date and a lower participation of Medicare enrollees (the January budget assumed 90 percent participation and the May Revision assumes 60 percent participation).

Please also note that the Coordinated Care Initiative was discussed at the following Senate hearings:

- Senate Budget and Fiscal Review Committee hearing on February 23, 2012. The materials for that hearing can be found at: http://sbud.senate.ca.gov/sites/sbud.senate.ca.gov/files/FullC/2232012SBFRHearingAgendaMediCal%20ManagedCareIHSSIntegration.pdf

- Senate Budget Subcommittee #3 hearing on April 26, 2012. The materials for that hearing can be found at: http://sbud.senate.ca.gov/sites/sbud.senate.ca.gov/files/SUB3/4262012Sub3DHCS.pdf

Additionally, there is a detailed discussion of the Administration's January proposal in the Senate Budget and Fiscal Review Committee's Overview of the 2012-13 Budget Bill, starting on page 3-1: http://sbud.senate.ca.gov/sites/sbud.senate.ca.gov/files/overview/OverviewOfThe2012_13BudgetBillSB957.pdf

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open as discussions continue with stakeholders, federal CMS, and the Legislature.

Questions. The Subcommittee has requested DHCS to respond to the following questions:

1. Please provide an overview of the May Revision changes to the CCI.

2. Please provide an update on DHCS' discussions with CMS regarding this demonstration proposal, including any feedback from CMS on the federal/state sharing ratio of Medicare savings.

3. Please highlight some of the key discussion points and issues that have been raised during the stakeholder meetings.

4. During the past budget committee and subcommittee hearings on the CCI, the Legislature has expressed a strong interest (if this proposal is approved) in developing a process to monitor and learn from implementation of the demonstration project to inform the potential future transition of additional counties. The May Revision does not include such a process or plan. Please comment why this is not included and if the Administration thinks this an important mechanism to ensure that the implementation of the demonstration is successful.

5. Community-Based Adult Services Program (DOF Issue 125 and 107)

Budget Issue. In the May Revision, the DHCS requests an increase of $71.7 million General Fund due to a revised estimate of the number of former Adult Day Health Care (ADHC) enrollees eligible for the Community-Based Adult Services (CBAS) program. The January budget proposal estimated that 50 percent of ADHC enrollees would be eligible for CBAS. The May Revision projects that 80 percent of ADHC enrollees would be eligible for CBAS.

Additionally, in the May Revision, the DHCS requests five limited-term positions to implement and operate the Community-Based Adult Services (CBAS) program. DHCS proposes to redirect existing limited term Adult Day Health Care (ADHC) positions (five limited-term and one permanent positions) to perform this workload. However, the limited-term positions expire on December 31, 2012. Consequently, the term of these newly proposed five limited-term positions would begin January 1, 2013 and expire August 31, 2014. The term of these positions corresponds to the time period of the Settlement Agreement. Additionally, the 1115 Waiver requires these services to be available until August 2014. Funding for the positions is noted in the table below.

Table: Proposed Funding for CBAS Positions

Year	General Fund	Federal Funds	Total Funds
2012-13	$162,000	$196,000	$358,000
2013-14	$280,000	$321,000	$601,000

The role of DHCS staff will be to oversee the transition of ADHC to CBAS and to provide contract oversight and monitoring of the managed care plans as CBAS becomes a managed care benefit on July 1, 2012. Essential activities conducted by DHCS staff would include:

- Instituting program improvement and performance expectations with CBAS providers.
- Ensuring appropriate utilization of CBAS center services.
- Overseeing and monitoring health plan contracts as they relate to CBAS services.
- Working with health plans to provide enhanced case management to CBAS participants.
- Supporting performance measurement, enrollment, and state hearing coordination to ensure health plan members receive medically necessary covered services.

Background. AB 97 (Statutes of 2011) eliminated ADHC as an optional Medi-Cal benefit to provide for an estimated $170 million in General Fund savings in 2011-12. The 2011 budget provided $85 million (General Fund) to provide for a temporary transition program for existing ADHC enrollees to other Medi-Cal appropriate services. As part of this transition, the Legislature provided for the development of policy legislation to create a federal Waiver program, but the Governor vetoed this budget bill language.

Settlement Agreement. Consequently, through the summer and fall of 2011, the Administration developed a transition plan for existing ADHC beneficiaries. However, as part of the settlement of a lawsuit that challenged the elimination of the ADHC benefit, an agreement was reached between the state and the plaintiffs to phase out the ADHC program and replace with a new program called the Community-Based Adult Services (CBAS) that will

provide necessary medical and social services to those with the greatest need. CBAS will be provided as a Medi-Cal managed care benefit no sooner than July 1, 2012.

CBAS Eligibility. At the time of the settlement, DHCS had estimated that roughly half of the "settlement class" (approximately 40,000 individuals who received ADHC services on or since July 1, 2011 through February 29, 2011) would qualify for CBAS; however, it is now estimated that approximately 80 percent of the class would be eligible.

Eligibility to participate in CBAS would be determined by state medical professionals on the basis of medical need, and the benefits provided would be coordinated with managed care plans. The CBAS program was originally expected to be implemented on March 1, 2012, but was not implemented until April 1, 2012, because of delays in getting federal CMS approval.

Contempt Motion. At the end of March 2012, Disability Rights California (DRC) filed a contempt motion stating that DHCS had not been following the terms of the settlement agreement. Since then, DRC and DHCS have come to agreement on the following:

- Both sides agree that DHCS will not be required to conduct further presumptive eligibility reviews.
- Both sides agree that a denial of presumptive eligibility is not appealable at a fair hearing.
- Both sides agree that the 37,000 people with disabilities and seniors who are part of the settlement class and were determined ineligible for the new CBAS program prior to April 1, 2012, who were not eligible to receive CBAS-pending, but who prevail at their respective fair hearings, will be deemed eligible CBAS retroactive to the date of CBAS implementation, April 1, 2012.
- The DHCS will coordinate with DRC and the California Department of Social Services State Hearings Division to offer optional telephonic hearings for the settlement class.

The other issue discussed in the contempt motion is the quality assurance process for the more than 315 eligibility determinations from 13 ADHC centers. DRC withdrew this contempt motion because it found that individuals who were first deemed eligible for CBAS through a state-run assessment and then subsequently deemed ineligible can still exercise their rights through fairness hearings.

Subcommittee Staff Comment and Recommendation—Approve. It is recommended to approve the funding adjust to reflect the anticipated CBAS caseload and to approve the request for positions to implement and operate CBAS. This proposal is consistent with the terms of the Settlement Agree.

Questions. The Subcommittee has requested DHCS to respond to the following questions:

1. Please provide a brief overview of these proposals.

6. Expand Medi-Cal Managed Care to Rural Counties

Budget Issue. Beginning in June 2013, the Administration proposes to expand Medi-Cal managed care into the 28 rural counties (listed below) that are now Fee-For-Service (FFS). This proposal would result in General Fund savings of $2.7 million in 2012-13 and $8.8 million in 2013-14.

Table: Medi-Cal Fee-For-Service Counties

County	Number of Medi-Cal Eligibles
Alpine	204
Amador	4,095
Butte	47,834
Calaveras	6,106
Colusa	4,271
Del Norte	7,706
El Dorado	17,216
Glenn	6,610
Humboldt	25,208
Imperial	54,563
Inyo	3,213
Lassen	4,544
Lake	16,556
Mariposa	2,599

County	Number of Medi-Cal Eligibles
Modoc	1,866
Mono	1,143
Nevada	10,452
Placer	28,269
Plumas	2,971
San Benito	9,334
Shasta	38,039
Sierra	458
Siskiyou	9,759
Sutter	21,724
Tehama	16,049
Trinity	2,628
Tuolumne	7,511
Yuba	18,857
Total	**369,785**

Subcommittee Staff Comment and Recommendation. On March 30, 2012, DHCS released a Request for Interest (RFI) in providing Medi-Cal managed care services in the 28 FFS counties. The DHCS indicates that it received many responses to the RFI and is evaluating these proposals.

It is recommended to reject the Administration's proposed trailer bill language on this proposal and instead, adopt placeholder trailer bill language to expand Medi-Cal managed care to rural counties beginning June 2013 and require DHCS to engage with stakeholders on a discussion of what metrics might be used to ensure that the appropriate controls and oversight available with a locally sponsored plan would be specified under this expansion.

Questions. The Subcommittee has requested DHCS to respond to the following questions:

1. Please provide an overview of this proposal.

2. What are the next steps and how does DHCS plan to reach out to interested stakeholders and consumer advocates?

7. Default Managed Care Plan Assignment

Budget Issue. The Administration intends to change how it selects a default managed care plan when a Medi-Cal enrollee does not make a health plan selection. The Administration proposes to consider health plan cost in addition to quality of care and safety net population factors as part of the default algorithm. Specifically, the default algorithm would be adjusted to increase defaults to low cost plans by 5 percent.

Savings would be recognized based on the shift of beneficiaries that would have been defaulted to the higher cost plans under the normal default ratios to lower cost plans. General Fund savings for 2012-13 are projected to be $2.4 million and $5.8 million for 2013-14.

This default algorithm would be implemented for Geographic Managed Care (GMC) and Two-Plan counties with the exception of Kings and Madera counties. Managed care is new in these counties and, consequently, plans in these counties are currently paid the same capitation rate since health plan quality data is not yet available. It is anticipated that beginning on January 1, 2013, plans in these two counties would use the proposed default algorithm (as health plan quality data would be available).

As shown in the table below, a majority of these savings are the result of the change to the default algorithm for the Family aid category.

Table: Default Algorithm Savings Per Aid Category

	Total		**SPDs**		**Family**	
2012-13	Total Funds	General Fund	Total Funds	General Fund	Total Funds	General Fund
Health Plan Default Assignment Method	-$5,256,000	-$2,628,000	-$188,000	-$94,000	-$5,068,000	-$2,534,000
Defer Managed Care Payment	$438,000	$219,000	$16,000	$8,000	$422,000	$211,000
Total amount	-$4,818,000	-$2,409,000	-$172,000	-$86,000	-$4,646,000	-$2,323,000
Total %		100.00%		3.57%		96.43%

Background. When a Medi-Cal enrollee does not select a Medi-Cal managed care plan, a default health plan is assigned. Currently, the default algorithm defaults beneficiaries into a plan based health plan quality (6/8 of the weighting, using six HEDIS measures) and safety net population factors (2/8 of the weighting). This algorithm is based on Family and Seniors and

Persons with Disabilities (SPD) aid categories. DHCS has regulatory authority to determine how assignments of default beneficiaries are to be made.

In 2011, 40 percent of new Medi-Cal managed care enrollees were defaulted into a health plan. See table below for more specific information.

Table: New Medi-Cal Managed Care Enrollee Health Plan Assignment for 2011

Plan Type	New Enrollment	Choice		Defaults					
				Linked to Prior Plan		Auto Assigned Using Algorithm		Combined Defaults	
	Totals	Totals	% Total Enroll	Totals	% Total Enroll	Totals	% Total Enroll	Totals	% Total Enroll
GMC	230,801	143,974	62%	26,440	11%	60,387	26%	86,827	38%
Two-Plan	1,336,706	796,620	60%	189,135	14%	350,951	26%	540,086	40%
Combined	1,567,507	940,594	60%	215,575	14%	411,338	26%	626,913	40%

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open as discussions continue regarding the Administration's proposals to expand Medi-Cal managed care.

Questions. The Subcommittee has requested the Administration respond to the following question:

1. Please provide an overview of this proposal.

8. ACA Primary Care Provider Payments

Budget Issue. In the May Revision, the DHCS proposes trailer bill language to increase certain physician primary care service rates to no less than 100 percent of the Medicare rate for specific services beginning January 1, 2013 to December 31, 2014, as required by federal health care reform. Since the state must restore these rates to the level of payment in effect on July 1, 2009, $38.7 million General Fund is needed to restore this payment rate level.

Background. The Affordable Care Act (ACA) requires Medi-Cal to increase certain physician primary care service rates to no less than 100 percent of the Medicare rate for specific services beginning January 1, 2013 to December 31, 2014. For services furnished during this time period, the federal CMS provides for 100 percent federal funding for the differential between Medi-Cal baseline rates (the level of payment in effect on July 1, 2009) and Medicare rates. Regular federal matching applies for any payment amounts above the minimum requirement or for any increases necessary to achieve the July 2009 rate.

After December 31, 2014, CMS will no longer provide 100 percent federal funding for the difference between the level of payment in effect on July 1, 2009 and 100 percent of the Medicare rate. The level of federal funding for the incremental difference in payments will revert to the regular funding level of 50 percent federal funds and 50 percent General Fund if the State decides to maintain the increased payments. Maintaining the higher levels of payments after December 31, 2014, will require additional General Fund dollars. Since the State is currently not in a position to commit increased General Fund necessary to maintain the incremental increase in payments to 100 percent of Medicare for the primary care services and services related to immunization administration for vaccines and toxoids, the incremental increase in payments will sunset on December 31, 2014.

Subcommittee Staff Comment and Recommendation—Approve. This proposal is consistent with federal law and provides incentives to strengthen the primary care workforce in preparation for health care reform. It is recommended for approval.

Questions. The Subcommittee has requested DHCS to respond to the following question:

1. Please provide an overview of this proposal.

9. Use of First 5 California Funding for Medi-Cal (DOF Issue 129)

Budget Issue. The budget proposes to use $40 million in Proposition 10 Funds to fund Medi-Cal services for children (aged five and under) to offset General Fund support in the program for 2012-13.

Background. The California Children and Families Program (known as First 5) was created in 1998 upon voter approval of Proposition 10, the California Children and Families First Act. There are 58 county First 5 commissions as well as the State California and Families Commission (State Commission), which provide early development programs for children through age five. Funding is provided by a Cigarette Tax (50 cents per pack), of which about 80 percent is allocated to the county commissions and 20 percent is allocated to the State Commission.

County commissions implement programs in accordance with local plans to support and improve early childhood development in their county. While programs vary from county to county, each county commission provides services in three main areas: (1) Family Functioning; (2) Child Development; and (3) Child Health.

Subcommittee Staff Comment—Hold Open. In previous analyses, the LAO has recommended a redirection of Proposition 10 Funds to support certain health and human services programs. They noted that Proposition 10 was approved by voters during a healthier fiscal period for California, and with the State facing continued hardship with the Great Recession, it would make fiscal sense to prioritize core children's programs.

Questions. The Subcommittee has requested the DOF/DHCS to respond to the following questions.

1. Please provide a brief summary of this proposal.

2. What is the status of discussions with First 5 on this proposal?